MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, December 13, 2001
10:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Assessing payment adequacy and updating Medicare payments: introduction, home health services, skilled nursing facilities – Jack Ashby, Nancy Ray, Sharon Bee, Sally Kaplan

MR. HACKBARTH: Next on the agenda is assessing payment adequacy. We'll have a series of discussions about various services and these discussions, for those of you in the audience, lead ultimately to our recommendations about updates for different types of providers. Jack and Nancy are going to introduce this.

MR. ASHBY: We're introducing the topic for all of the services. Nancy and I have been switching back and forth and I guess this month it's my turn.

At the last two meetings we have been discussing a model that breaks the updating process for fee-for-service down into two components. As we can see in our now familiar chart the two components are assessing the adequacies of current payments and then accounting for increases in efficient providers costs for the next year.

Today we're ready to try our hands at applying this model for our update recommendations for fiscal year 2003.

Because we have gone over this model at both of the last two meetings, I was not planning to review the steps in detail again. But we did want to stress just a few points about the process.

The first point we wanted to make is that the approach that we've developed is not really fundamentally different from what the Commission has been doing for years. What it does if formalize separation of the two parts, where before the question of whether current payments were right was sort of implicit or intertwined with the question of the appropriate increase for the next year.

We'd like to suggest that the process might well go more smoothly if we do, in fact, move through the two steps sequentially rather than just jumping right to the update. We have all organized our presentations around doing just that.

The second point was I wanted to try and head off confusion about the very word update. When we say update, we mean the sum of these two component changes that we're presenting in the model here and not just the allowance for cost increases in the next year. In the past, it hasn't always been clear what a reference to update meant, whether it was accounting for cost increases next year or something broader.

Or to put this another way, when we have seen an update, like for example market basket minus 1 percent as just an example, it wasn't always clear what the minus 1 was supposed to represent, that we expected cost increases to be less than the market basket for some reason or that current payments were too high, or perhaps just that Congress needed savings.

So, at least for MedPAC's recommendations, our hope is that the new system will make it clear why we think that market basket should come with a plus one or minus one, or whatever.

If we could turn to the next chart, I wanted to make a

related point here. In this chart, again which should be familiar by now, we have taken the first major step, assessing payment adequacy, and broken it down into three substeps, I guess you'd call them, that we've conveniently called estimate, assess and adjust.

At the adjust point, we have talked about the possibility of addressing distributional questions in the process. At four different places over the next two days, I believe it's four places, staff will be raising potential distribution adjustments for your consideration.

The thing we wanted to stress is that this is still part of stressing payment adequacy. When we raise these distributional issues we're not talking about expecting one group's costs to increase less than another group's costs in the next year. What we are talking about is the potential conclusion that perhaps payments are more than adequate for one group of hospitals and less than adequate for another group of hospitals, or SNFs, or whatever provider group we're on.

Then, one last clarification. In the box on the left, estimate current Medicare payments and current Medicare costs. We had some confusion at the last meeting about the word current. We really didn't mean to describe our 1999 data as current. We all sort of suffered with that problem.

What we're talking about here is our best estimate of the payments and costs as of 2002, since our job is to recommend an update for 2003. The last time we had the word measure in this box and it sort of occurred to us that when we're talking about 2002, we certainly are not talking about measuring. At best, we are talking about estimating, not only due to data lags but due to the fact that we're called on to make a recommendation for FY 2003 when we're not even a quarter of the way into 2002.

That's a good lead-in for taking a moment to explain how we did our modeling for 2002 payments and costs. In each case, we began with nearly complete 1999 data. And then, as we see here, we did three different things.

I have to apologize here. I noticed that the handouts got into reverse order here somehow. So we're on this page.

Three things we did to do our model. One is we applied the updates that are in law for 2000, 2001 and 2002. That's pretty straightforward.

Secondly, we estimated the unit cost increases over that same three-year period. That, of course, is not at all straightforward, especially given that we don't have 2000 cost report data available this year, as we normally would have at this point in the process. So certainly, our estimates have to be seen as having a margin of error around them, mostly the cost side.

We used alternative sources of data to estimate those cost increases where they're available, but basically we only had alternative sources available in he hospital sector. None of the others really offered us anything to work with. Then, when we did not have data, we made what we think is a pretty reasonable assumption that unit costs would increase at the rate of the applicable market basket. That would apply to all of our sectors

for 2002, since obviously that's mostly still future and that's a forecast. It applies to all of the sectors except hospital for 2000 and 2001.

Then, the third thing that we did is model other policy changes that have actually been legislated and were implemented at any time from 1999 on to 2003.

So just to clarify here, we're talking about an estimate of payments and costs for 2002 but we have looked at payments as if 2003 rules were in effect. We thought this was the best way to present the scenario that providers are faced with going into the year for which we are developing updates.

Then quickly, on the last overhead, this lists the six services that we are taking on over the next two days, along with four facility-based services that we're not addressing right now. Rehab, psych, and long-term hospitals are all on the TEFRA payment system, which is being phased out. There's probably little reason to focus there. ASCs, on the other hand, it's really more of a workload issue. When time permits, we probably will want to assess payment adequacy in that sector as well.

So if there are any questions on the general process we can take that now. Otherwise, we'll move up to the first batter.

DR. ROWE: With respect to the general process, the model that's used or the goal that's used to assess appropriateness of current cost presumably goes back to the goals of the Medicare program. Is that the way it works? You have those here in the text. You don't want to overpay, you don't want to underpay. You want to provide access to high quality care, et cetera.

MR. ASHBY: Right.

DR. ROWE: Is there any consideration in that -- I'm going back to the old argument Judy Lave and I had a couple of years ago here about what the right number is. Here's where I'm coming from, just to give you my sense. I'm concerned that a lot of these institutions, at least the hospitals, don't have as much access to the capital markets as they used to to sustain themselves, for a variety of reasons. The one I used to run had its bonds downgraded recently, et cetera, et cetera. 70 percent in California have had their bonds downgraded.

So they don't have as much access to capital as they used to. It's not as clear that they're going to be able to sustain themselves so that the Medicare beneficiaries have access to quality care.

Is there any consideration anywhere in the formulas for these kind of economic changes that influence the capacity of these institutions to have capital to invest?

MR. ASHBY: You'll notice on the set of boxes we were looking at we did indeed list the cost of access to capital as a consideration. To the best of our ability, we're trying to do that. It's a different thing to really assess.

I think that we probably would be best to hold that discussion for this afternoon when we deal with hospitals. That's where the issue has been acute and we have some information to put out. It's a very important thing to discuss.

DR. ROWE: It's just that of all the things on this list, that seems to be the one that is getting worse, more so than some

of the others.

MR. ASHBY: Than some of the others, right.

MR. HACKBARTH: Okay, should we proceed with SNFs?

MR. ASHBY: Home health first, I believe.

MS. BEE: The first sector we'll discuss this morning is home health.

As we've just reviewed, the key questions for our discussion this morning are several indicators that I presented last month that we'll review to assess whether payments are adequate in the home health perspective payment system. Next, we'll add some discussion of how costs are going to change over the next year, and then begin to pull those two ideas together in our update framework.

We do not have cost reports from agencies under the PPS to estimate current costs for this sector. We've used several market factors as indirect measures of the relationship of payments to costs. My first market indicator, according to the OIG, beneficiaries continue to maintain good access to care. This is true for both those discharged from the hospital and those beneficiaries that are entering care from the community.

In the past we have seen substantial movement of providers in and out of this program. However, in the past two years the number of agencies participating in the program has stabilized. Entering and exit have slowed. The fluidity of this market makes entry and exit a reasonable indicator of the relationship of payments to costs, but I'll note again though, changes in the number of agencies are not a good indicator of the capacity of the home health care in the program.

My last market condition, some observers expected to see an increase in the volume of episodes. Instead, preliminary data suggests that many beneficiaries complete their care in only one episode. And if the per visit payments for very short episodes were too low, we would expect to see extra visits added to avoid low revenue episodes. Instead, the proportion of episodes with four or fewer visits has remained about the same as it was before the implementation of the PPS.

In our overall analysis of these market conditions, we find no compelling evidence that current payments are not adequate.

The next step is to estimate how providers' costs will change between 2002 and 2003. Our default measurement of changes in the price of inputs used to provide home health services is the forecasted market basket. Changes in the product may cause costs to grow more slowly than the market basket.

Incentives have been changing. The old cost-based system had only weak incentives for efficiency. The cost limits under the IPS encourage better supply use and more efficient travel. Under the PPS, episode payments are the same whether 30 visits or 16 visits are delivered. We would expect the number of visits to decrease under the prospective payment system as we encourage the management of costs within an episode.

On this indicator, as the Commission has noted, the absence of clinical practice standards also constrains our ability to relate differences in service use to failure or success in meeting program goals. Declining use can be indicative of

greater efficiency, a shift in care toward restoring independence and away from fostering dependence, or a failure to meet the needs of the chronically ill. It is very difficult to interpret this data.

The preliminary data that we have seems to suggest that visits per episode have been declining under the PPS.

In HCFA's PPS demonstration, prospectively paid agencies significantly decreased the number of visits per episode compared to agencies still paid on costs. However, prospectively paid agencies in the demonstration also increased their costs per visit. This corroborates anecdotal evidence that visits under the PPS are longer, maybe more expensive visit types are replacing less expensive ones, an increase in the use of therapy and a decrease use of home health aid, and the use of non-visit services such as remote or telehealth monitoring or advanced wound care techniques have increased.

Thus, decreasing visits per episode will lead to decreased costs per episode only to the extent that it is not offset by rising costs per visit.

In the face of such uncertainty regarding both the current relationship of cost and payments and likely changes in costs, market basket could be an appropriate update. The update in current law for this sector is market basket minus 1.1, which we could also find is within a range of appropriate update factors.

My last slide brings two policies to your attention that both have payment implications for this sector. The so-called 15 percent cut currently scheduled for October 2002 is the last phase of a process begun in the BBA of 1997 to reduce spending on home health services. If implemented, this policy would reduce the base rate of the PPS.

The legislation which started the transformation of the home health system was conceived in an environment of high and escalating home health spending. The changes were intended to reduce spending and redirect the benefit towards shorter, more intense episodes. Our data seems to indicate that providers have responded to the policy changes.

Total Medicare spending on home health fell 52 percent from 1997 to 1999. Fewer beneficiaries per 1,000 Medicare beneficiaries use home health. The volume of visits per user has decreased. Total average home health length of stay has declined. And the proportion of home health users who use therapy, a relatively intense service, has increased and the use of home health aides, a relatively low intensity service, has decreased.

So we now have much less spending on a home health benefit that seems to provide more intense services in fewer days to fewer people. Without clinical standards or a clear definition of the benefit, we still cannot know if we've achieved the long-term goal of buying appropriate services. However, evidence suggests that the short-term intent of the process begun in the BBA has been substantially achieved.

The options that we could consider regarding this policy would be perhaps to eliminate the cut or to postpone the cut.

The second policy with substantial payment implications is

the 10 percent add-on. BIPA legislation has provided a 10 percent higher base rate for home health services provided to beneficiaries who reside in rural areas, which is to say outside of MSAs, since the implementation of the PPS. This add-on is scheduled to sunset in April of 2003.

In June of this year, the Commission concluded that the new PPS should work equally well in both urban and rural settings based on our analysis of the components of the PPS. And we have no evidence that PPS payments generally are not adequate relative to costs.

However, in June we thought it was possible that rural costs per patient could be higher than urban costs due to small-scale of operations, the distance traveled between patients, and differences in the use of therapy.

We do not have measurements of payments and costs in rural areas but we do know this: discharge planners at urban and rural hospitals were able to place Medicare beneficiaries in home health at similar rates.

We have no data on the volume of care in rural areas since 1999. However, the number of home health users per 1,000 beneficiaries declined significantly more rapidly between 1997 and 1999 in rural areas, down 26 percent, than it did in urban areas, down 19 percent. And the rate of exit of agencies in rural areas was greater than that in urban areas.

Again, we have no evidence to suggest that payments are over adequate or inadequate for the system generally. It is possible that costs differ in rural areas but we have no measurement of rural payments and costs. Given this uncertainty, it may be appropriate to continue the add-on payment for one more year.

The two options we could consider regarding this policy are that the rural add-on not be allowed to sunset in April of 2003 but be instead extended for one more year. This you could characterize as a risk-adverse option. If we wish to be cautious about reducing payments by 10 percent without evidence about the current adequacy of payments, we may urge the extension of the add-on.

Option two would be that the rural add-on should be allowed to sunset as currently scheduled, in April of 2003. On the other hand, we have argued against special payment provisions of just this sort. If there are shortcomings in the PPS, we should diagnose the malady and cure it, rather than apply a one size fits most bandage to the symptoms.

This concludes my prepared remarks and brings us to the action items for our discussion today on this sector. Staff asks the Commission to consider recommendations on the adequacy of the base rate, the update factor, the 15 percent cut, or the rural add-on.

DR. LOOP: This is an informative chapter. I thought your conclusion about the base payment being adequate is possibly premature because we are only at the end of the first year of PPS and you point out, in the text, that you don't have cost reports from agencies under PPS to estimate the current costs.

So what I think you're saying is in the absence of data, everything is fine. And I'm not sure that's correct. I'd like

to hear from Carol, who's the real expert in this area.

MS. RAPHAEL: As I step back, my main concern is that we try to maintain some stability in this sector. I think you have to look at the last three years, where we went from a cost-based reimbursement to an interim payment system, to a prospective payment system with no transition at all provided.

And so my own view is that we need to do watchful waiting and not draw any conclusions at this juncture or do anything that would further destabilize this sector.

I think that you're right, Sharon, in making the point that Congressional intent was to try to change the incentive so that volume would not continue to increase and to try to restrict the benefitting carve-out to some degree, the part that was perhaps attributable to long-term care supportive services. And we, in this Commission, should be encouraged by the fact that we were worried about stinting and attempts to try to utilize the fact that you could have unlimited episodes and this LUPA or short visit portion.

And the preliminary data, in fact, indicates that, as Sharon pointed out, 90 percent of the patients getting care in the top diagnoses are getting it within one episode. And what was estimated to be the percentage of these short visits is, in fact, very close to what we're seeing. And people are not giving someone a fifth or sixth visit in order to bump them into the higher paying episode. So I think that all, for me, is quite remarkable and reassuring.

I think that are some dynamics that are important here. One is that all of us have had to invest in technology and many organizations don't have access to capital to make those investments in technology, because we had to do a system for interim payment, a system for something that I won't even go through which is quite esoteric called sequential billing. We had to do a system for prospective payment.

So in the course of three years, we've had to implement three major billing systems that are quite costly. I think that is an issue for the sector. In addition, I don't think we know enough about what's happening to the mix of visits. We know that visits are declining. All early indications lead us to that conclusion. But we don't know exactly what the components of the new episodes of care. And we also don't know exactly how long these visits are, what has happened to productivity.

I think there are issues in the home health sector that are different from some of the other sectors, because it is hard to substitute service. I mean, there's a lot of talk about telemonitoring. My own view is that is not in widespread use. It has not gone through diffusion yet. It's sort of a few boutique programs.

We can't substitute licensed practical nurses and nursing assistants to the same degree that other sectors have. So I think this whole issue of substitutability needs to be examined in much greater depth.

So my own kind of sense on all of this, at this point, is that we shouldn't jump to quick conclusions, that we should keep kind of watching and monitoring how this evolves.

MR. DEBUSK: I think there's something else here we might take note of. In the post-acute area, we've come up with some prospective payment systems that have not been too successful. And here, this OASIS system which has 80 categories, I'm sure there's some further refinement but there might be a chance that we've done something pretty close to being right here.

We might take note, as we go forward at looking at these other systems in the form of assessment and maybe expand upon some of this for this post-acute area.

So all in all, I think this has worked pretty well. But I think we should stay where we are at. I don't think we can stand to cut at this point. I don't think we need to break it if it's not broke. We need to take a further look.

MS. BURKE: Two things. One going to Carol's point. I think I absolutely agree with what she has suggested about the need to allow some stability to occur for a period of time. I wonder if, in fact, we might not comment in the text on that fact. Not only do we not have the data to be able to make an adequate decision on an adjustment but, in fact, what the sector has dealt with over the last three years in terms of the implementation of a variety of systems that have had an impact on that particular sector, I think we might in fact comment on that specifically.

I also worry, frankly, as I look at what we'll have to look at going forward, as to whether or not in fact we believe that within a year -- because the comment is to delay for a period of time -- whether we think a year, in fact, is going to be adequate to give us the information necessary to make a decision both on the cut as well the rural adjustment.

My experience, old as it is, is that it never happens as quickly as we anticipate and the data is never very good very quickly. So I wonder if, in fact, we ought to say that there isn't going to be this issue of whether or not the data is going to be adequate within that period of time, whether we'll have enough on the books. My guess is we won't, but I wonder if we might not make a comment on that as well, as to how quickly.

Because again, I think the sector needs some stability for a period of time, which is not to suggest you want to pay at an inappropriate level for any extended period of time. But I also think we do tend to rush to judgment and it's not clear to me how quickly we'll get that kind of information, for the reasons that Carol suggests.

MR. HACKBARTH: Sharon, any reaction to that point? It makes a lot of sense to me.

MS. BEE: I guess my question would be would the recommendation then be for some kind of postponement in a unit larger than one year? Does that move you toward thinking about eliminating the 15 percent cut as a recommendation? How far down that road do you want to go?

MR. HACKBARTH: My thinking about it would be not to eliminate it entirely, but stretch it out for what we think is a reasonable period that will allow us to evaluate these things. I don't know if that's two years or -- but to every year come back and say is this the year that we're going to have the 15 percent

cut doesn't appeal to me as a process.

DR. NEWHOUSE: I was actually coming from much the same place Sheila was but I was going to see her and raise her one. I don't have any confidence that in a year, or even two years, we'll be in a much better place. I have not problem with postponing the 15 percent cut and postponing the rural sunset provision.

But I thought we ought to add a recommendation here, and probably in the SNF chapter and maybe some others as well, that probably AHRQ should be given some money to research standards in this field. I mean, home health has been incredibly labile, as we all went up like a rocket and then down like a stone. Nobody seems to have much of a clue about what happened during all that period.

I think at the rate we're going, we're likely to be in that position downstream. So to get us out of that box, and I think it will take a few years, we need to put in some kind of recommendation for research on judging performance, adequacy, however we want to couch the words. But the idea is to essentially implement Jack's box on judging changes in the product. I don't think we know what we're doing here.

DR. REISCHAUER: Just as a matter of interest, when we have suggestions like this it would be nice to know how many billions of dollars we're talking about. But having said that and made myself appear to be a budgeteer, let me say that I would go one step further than either of my two esteemed colleagues, and I would say it's time to recommend eliminating the possibility of the 15 percent.

I see no evidence here that we could be anywhere near 15 percent overpaying these entities. If we're overpaying them, and I kind of think from what I read in the tea leaves that that isn't the case, it's a percentage point or two. And isn't that what this new framework is supposed to pick up later on? So why add uncertainty? Let's just bite the bullet and make a recommendation saying no 15 percent cut. And then if it turns out well, that was a little bit wrong when we come back three years from now or two years from now or whatever, it will show up in this new framework as a base payment that's a little out of whack.

Going on to the base payment discussion, which Joe started, I was going to say something when Jack was up there about this framework. That is that I think one of the questions should not be sort of product but quality, because for some of these sectors that we're talking about like home health, in effect, Medicare is the game for all practical purposes. You lower the payments and costs are going to come down. By definition, there's nowhere else for them to go.

We can look at access but one access is one dimension of a multi-dimension output. The other dimension is quality really. The quality can be deteriorating and it's highly likely that we can't say a whole lot about it, but we should at least make the world aware of it, that this is important.

MS. BURKE: Bob raises quite a good point because presumably there's been some adjustment in the baseline. What, in fact, did

they carry in the '02 baseline for the 15 percent? And do we know what they carry in the '03 for the 10 percent?

MS. BEE: I can certainly bring you the estimates that we have on this.

MS. BURKE: Somebody will have to eat that, we may as well know what it is.

DR. ROSS: It will be revised between actually now and when we meet next, to set new baselines.

DR. REISCHAUER: I don't think that should affect our decision, but it just might mean that we know how much armor to put on when we make it.

MR. HACKBARTH: Any other comments? What about the rural piece?

DR. REISCHAUER: I think there's a lot of reasons in that situation to say, continue for a year or two until some more information comes in, as opposed to the other.

DR. WAKEFIELD: Can I just be on the record to affirm that good point? I hate to lead on rural. You notice that I stepped back or sort of stayed in the weeds. But I'm with you, Bob. I want you to know that.

DR. REISCHAUER: I figured I was your front guy.

[Laughter.]

DR. ROWE: I agree with Bob's recommendation but I want to make sure I understand the logic here so we don't get into a trap. I want to make sure we're not saying that we're early on in our experience, we're in a data-free environment, we really don't have enough data to assess the appropriateness of the current payments. And based on the data available to us, we therefore decided that we don't want a 15 percent cut because we can't both have the data on the one hand and have enough data to indicate that this cut is not appropriate on the other hand.

So we need some bridge between those to make sure that we are making a statement that says that even though the data are early and incomplete it's quite clear, based on them, that it's highly unlikely that a 15 percent cut would be appropriate. Is that what you're saying?

DR. REISCHAUER: I don't think it's true that we have no data. I mean, we have data through June of this last year on numbers of agencies on visits, on things like that, which would be flashing red lights if we were paying 15 percent too much or 20 percent too little. That's all I'm saying.

DR. ROWE: I think that's what I'm saying.

DR. ROSS: I just wanted to weigh in with Bob on that. The 15 percent is a big number. When things are off by that much, you will see entry, you will see other changes. And it falls on the heel, as Sharon said, of a 50 percent reduction in spending. Those are big changes.

MR. HACKBARTH: Just for my information, the 15 percent cut is from an old baseline. So it would actually be a 6 percent cut, if I read the material, from current levels; is that right?

MS. BEE: We'll get an updated estimate from CMS on what that would be. They're right now working on plugging in the most recent data available to make that estimate. But that's correct.

MR. HACKBARTH: Roughly, something like that.

MS. BEE: That's my impression.

MS. RAPHAEL: I just wanted to reaffirm what Joe said. I do think we need to look into this further. This 52 percent drop in expenditures in the course of two years, and the drop of beneficiaries per 1,000, needs to be explored. And we really need to gain some better understanding of what is going on.

Because once again our main measure of access is talking to discharge planners in hospitals. We know 38 percent of the people who come into the system come in through physicians and the community. We just really need to have a better sense to just feel confident that access is not diminished in this area.

MR. HACKBARTH: We still need to do the SNF piece in the next 25 minutes. Have we gotten to a point on home health that you, Sharon and Murray, have what you need?

MS. BEE: Yes.

MR. HACKBARTH: Okay, so what I'd like to do is move ahead. Thanks, Sharon. Sally?

DR. KAPLAN: Now we're going to talk about SNFs.

At the end of my presentation on payment adequacy, you'll need to give me a sense of the direction of your decisions, where you think you're going. There are four decisions that you need to make between now and the January meeting, or between the end of January meeting.

First, whether the base payment is too high, about right, or two low. Second, you'll need to decide whether the distribution of payments is appropriate between freestanding and hospital-based SNFs. If you decide the distribution is inappropriate, you may want to do something about it. And finally, the update.

We'll stop for you to discuss the decision points on payment adequacy before we talk about the update for fiscal year 2003.

In deciding if payments are adequate, we first ask if costs are appropriate. SNF costs were very high under the cost-based payment system. There was rapid growth in Medicare spending for SNF care from 1990 to 1996, averaging 23 percent increase per year. Most of this increase was due to growth in ancillary services for which SNFs were paid on a cost basis. Both the GAO and the OIG have consistently maintained that costs were overstated during this period.

Under the PPS, SNFs had room to cut their costs and they apparently did, by renegotiating contracts for therapy and drugs, by substituting low-cost employees for higher cost employees, and by cutting therapy staff.

Freestanding SNF costs appear to be appropriate. Their costs per day decreased from $305 per day in 1998 to $240 in 1999. Hospital-based SNF costs, however, are much more difficult to interpret. Hospitals have historically allocated costs to their SNFs, making those costs overstated. How much those costs are overstated is not known. The estimate on hospitals' cost allocation to outpatient departments is 15 to 20 percent, but we don't know whether hospitals allocate more, less, or the same percentage to SNFs.

Jack described pretty much what we do in modeling, but I'd like to bring up several points, because we're considering an update recommendation for fiscal year 2003. We've also

considered four payment policy changes scheduled to occur in that year.

First of all, SNFs will be paid at 100 percent federal rate in 2003, which is the end of the phase-out. We included the temporary rate increase that remains in effect until the RUG-III classification system is refined. That is 6.7 percent increase for rehabilitation patients and a 20 percent increase for medically complex patients.

We did not include two temporary rate increases that expire in fiscal year 2003 under current law. That's a 4 percent increase across the board and a 16.66 percent increase in the nursing component base.

I'm going to show you the results of our modeling, but I want to point out that margins would have been higher in 2000 and 2001 than in either 1999 or 2002 because of these two additional add-ons. But those margins will not be reflected in the table you'll see next.

MS. BURKE: Sally, could you repeat that again?

DR. KAPLAN: We don't have 2000 and 2001 on this table that you see right there, and they would have been higher, margins would have been higher than either in 1999 or in 2002.

DR. ROWE: Because of these extra payments.

DR. KAPLAN: Because they have these extra bump-ups that are not included in 2003.

On this table we show margins for 1999 and three estimates for 2002. The first estimate uses costs as recorded by SNFs. The next one assumes that hospital-based SNFs costs were overstated by 20 percent. And the third one assumes that hospital-based SNF costs are overstated by 30 percent.

The situation is full of uncertainty. We know that hospitals allocate costs to the SNFs but we don't know how much. How much they allocate, however, has a big effect on the overall SNF margin. Even with this uncertainty, however, you will have to decide whether the base rate is adequate.

The other factors that we examined, besides the margins, do not suggest that the base rate is inadequate. The IG found that beneficiaries have had stable access to SNF care in 2000 and 2001. Freestanding SNFs have stayed in the program. In contrast, over 400 hospital-based SNFs have dropped.

Our best estimate is that overall estimated margins range from between zero and 3 percent, depending on how much hospital-based SNF costs are overstated.

DR. ROWE: Is that Medicare margin?

DR. KAPLAN: Yes, it's Medicare margin.

Is the distribution of payments appropriate? The margins suggest that the distribution is not appropriate. Payments are more than adequate for freestanding SNFs and less than adequate for hospital-based SNFs. 20 percent of hospital-based SNFs have left Medicare, which also suggests that payments are less than adequate.

There are several reasons for the difference between hospital-based and freestanding SNFs. First of all, we've already talked about the cost allocation. Second is the classification for the SNF PPS. The RUG-III is based on a

patient assessment instrument that does not collect the information needed to account for the needs of the more acutely ill patients found in SNFs. Also, the RUG-III does not appropriately target payments to the costs of providing SNF care, especially to patients needing costly ancillaries.

In our analysis of APR DRGs last year, we found that hospital-based SNFs case mix index was 11 points higher than freestanding SNFs. We don't know how much of a difference in costs this represents.

Another difference between freestanding and hospital-based SNFs is staffing. According to a study by CMS published last year, hospital-based SNFs have much higher staffing, more licensed direct care staff than freestanding facilities.

If you agree that the distribution of payments is inappropriate, then you need to decide whether an adjustment is warranted. The best way to fix a distribution problem caused by the classification system is to fix the classification system. However, that is easier said than done, as CMS has demonstrated.

CMS' attempt to refine the RUG-III in 2000 failed. That failure, in part, resulted in our recommendation that CMS develop a new classification system. However, 2006 would be the earliest that a new system would be available.

A temporary fix might be to have different updates for freestanding and hospital-based SNFs. However, that would translate to different basis and different basis might be a solution that would not be temporary. Politically, it is sometimes very difficult to get rid of temporary fixes to payment systems to begin with, and especially if they're in the base.

A third alternative, which is not on the slide, would be to use Congress' method, and that is to have an add-on for hospital-based SNFs. That would be easier to eliminate because it wouldn't be in the base.

I'd like you to discuss payment adequacy before we move to talking about the update, and that is whether the base rate or pool of money for SNFs is adequate, whether the distribution of payments between freestanding and hospital-based SNFs is appropriate, and if not, what should be done about it. Then we'll talk about the update.

DR. ROSS: Sally, I'm going to suggest to you, just because of the time, just go through what the market basket and current law --

DR. KAPLAN: Okay. The next slide is just some things you need to know about the update. First of all, any adjustment you decide on will carry over to the update decision. Current law is market basket minus 0.5 percent and the latest market basket forecast is 2.8 percent.

You need to consider whether an update of market basket would be adequate, whether current law is adequate, and all of that in the context of the various uncertainties we've talked about.

The last table in your handout is really to help you think about making your decisions for the update. That's it.

MR. HACKBARTH: Sally, help me connect some of these ideas. We believe that the hospital-based SNFs have sicker patients.

We're unsure how much that increases the costs, but our hunch is that it does increase the costs. In at least some areas, a lot of the hospital-based SNFs are going out of business. We don't think that those sicker patients are having problems getting access to care. We don't see any evidence of that. I assume that means more of them are now showing up in freestanding SNFs and the freestanding SNFs are doing well financially.

Does that mean that the freestanding SNFs are doing a more efficient job of handling a growing population of sicker patients?

There are all sorts of lags in terms of the information.

DR. KAPLAN: First of all, we have case mix for 1999, is the latest year we have the case mix. We don't have the claims for 2000, the SNF claims for 2000, yet.

I assume that those patients either would go to freestanding SNFs. I can't envision that a hospital-based SNF would necessarily take a patient from another hospital. I would assume, and I have nothing to base this on other than my intuition and having worked in a hospital, that they would take their own patients but they wouldn't necessarily take the high acuity patients from another hospital.

MR. HACKBARTH: Particularly if you're losing a lot of money.

DR. KAPLAN: Yes. The access statistics have stayed basically stable, 2000 to 2001. It is possible that hospitals are keeping patients longer. The hospital length of stay has gone up somewhat in the recent years that we have statistics for.

DR. REISCHAUER: I actually want to come at this a little different way and ask Ralph and Jack a question, which is does it make a lot of sense for hospitals to run SNFs? Is their cost structure, because of unionization, different agreements with nurses, et cetera, such that to produce the same product is just much more expensive?

And what we see when we change the payment policy is that this was brought home to hospitals, and so we shouldn't worry tremendously if we see the hospital-based SNF capacity of the nation shrink rather substantially because it was artificially high? And does the transfer policy have anything to do with this, as well?

DR. ROWE: My response I guess would be a couple points. One is, it certainly makes a lot of sense based on the financing mechanism because you can imagine a system where a hospital gets a DRG payment for a Medicare beneficiary and then fairly soon into the discharge transfers the patient to a SNF bed within the same institution and starts collecting a per diem for the same patient.

So from that point of view, to whatever extent that used to occur, that was a relative incentive for hospitals to have SNF beds within their facilities. I think that's important.

I think there have been some changes with respect to that, particularly transfer policies and other things, which may be at the basis of the reduction in the number of participating hospital-based SNFs that you can see.

From my point of view, I think that the major reasons to

have them were clinical. That is the physician who was the primary physician, who may have operated on the patient's hip or heart or something, was able to continue to see the patient in the SNF. That rehabilitation programs, which are very important programs, that inpatient acute rehab, would also be able to be established in the SNF area and treat those patients and use the same, in fact, facility for the rehab that the patients could be transported to.

There were these programmatic, clinical supervisory reasons which really improve the quality of care, were very physician friendly, and made these kinds of units very attractive to have within the facility. That's my thought. Ralph?

MR. MULLER: I would build on that in part by saying that the intellectual model of the last eight, nine years of trying to have integrated systems and avoid some of the difficulties of hand-off of patients from one setting to another, which we all know are very difficult to execute in practices versus whatever one might think in theory, cause people to try to control as much of these production processes as they could, even though the cost structure may have been inappropriate and unwieldy when you have the overhead of a hospital being allocated to a SNF. So I would second what Jack has pointed out.

I would also say that insofar as one thinks one is losing 50 percent on it, people will get out of that business very quickly, no matter what their concerns about integration, because you can't afford to lose 50 percent of margin.

I want to add to that, though, by saying there's this assumption that you must be around a lot more sophisticated hospitals than I've been around where these people allocate costs right and left, back and forth. You have to ultimately have your costs add up to 100 percent on a Medicare cost report, so this notion of people moving back and forth.

Now I want to say if, in fact, costs have been, in that sense, over allocated to SNFs and now these astute hospital executives will start allocating them more appropriately, that will add costs back to some other program, most likely the inpatient program. And that should affect our discussion later about maybe there's costs there that are coming back to the inpatient program that are understated. So we have to look at that in a symmetrical way.

I do think it's fair to say that within this exit of hospital-based SNFs, it may not be as quick as the exit of home health, but it will continue to occur at these kind of negative margins. So I think we do have to look and see whether there's a programmatic reason, as Jack indicated, to have these patients have access to this care.

I think there probably was too much of an incentive to go that way financially that added to the clinical imperative that Jack mentioned, and it may go too far now if we take them all away.

DR. WAKEFIELD: I have three comments. First of all a comment on the text under the appropriateness of costs. You've got some good references about how SNFs have been able to cut costs by substituting lower cost labor for high cost labor. I

think all in all that's always a good thing when it can happen, and there's not an accompanying decline in quality of care. Which isn't to suggest that there is, but there is the other side of that, the flip side of that picture. I'd always kind of want to have, to the extent one could, an ear toward that.

This by itself, doesn't necessarily speak to me as a good thing for a Medicare beneficiary. It might be exactly a good thing, both in terms of lowering costs and maintaining quality, but if we don't know the flip side of that, that's always a bit of a concern to me and something that's hard to get at. But keeping your finger on that side of the equation, I think, is important. By itself it doesn't make me feel terribly comfortable.

Secondly, I thought that the margins data on table two, obviously in terms of rural, are a little bit disconcerting, especially hospital-based rural margins, and even freestanding. It's good, at least it's in the positive side. But they're not walking away with a bank here, it would seem to me.

The last comment that I wanted to make is with regard to relying on the IG's querying of discharge planners and their ability to access SNF services for Medicare beneficiaries, I may think that is about the best we can come up with. And that is they say that generally speaking there's not a problem.

But I'd say again, from a rural side, just a question that nags a little bit at the back of my head. Would this still be the case if we asked that question of Medicare beneficiaries, for example rural Medicare beneficiaries? That is, do they have good access? They might have access. Is it anywhere near where they live? Is it in a town near where they live? Or is it the fact that a discharge planner can put them in a SNF, but it's not something that's available to them in some geographically reasonable area?

It's just trying to look at that question a little bit from the beneficiary side. I certainly don't know the answer to that. I'm just saying that the discharge planning piece probably gives us one part of the picture, and there may or may not be another part to that picture.

DR. LOOP: I think the reason that large hospitals still have SNFs is because of the clinical follow-up. I think Jack's answer is correct. But the reason they also lose money is that the severity of illness is a lot greater in hospital SNFs.

So maybe we should recommend that through the APR-DRG system we add that CMI rating to the RUG-III to try to differentiate the type of patients that are in freestanding versus hospital-based SNFs so that we can reimburse the hospital-based SNFs if, indeed, their severity of illness is worse.

DR. KAPLAN: I think that may be one of the alternatives that they're investigating for a new classification system. The difficulty is it wouldn't happen until 2006 at the earliest.

DR. LOOP: Why would you have to wait? Out of curiosity, why do you have to wait until 2006? I mean, there may not be too many more hospital-based SNFs by 2006?

DR. KAPLAN: I think it takes several years to get a new system in. And they're still just at the beginning of testing

alternatives. They just started on that this summer. I'm just trying to make you be realistic that we're not going to see anything before 2006. It's actually fiscal year 2002, now. The report to Congress is for January 2005, so we figured a year after that.

DR. ROSS: Sally, I think Floyd's point was, could you do something blunter in the interim, which is what the Congress tried to do in the last couple of rounds of legislation, although it's worth noting that the first time they did this to try and attach money to the medically complex and most expensive categories of patients, by the time the legislation was done they had expanded that list not quite across the board, but the amount of money they had to spend essentially got diluted across many more categories.

It may be worth revisiting that, and asking if shrinking that number of categories might be a crude proxy for getting at the higher case mix.

MS. BURKE: Sally, I just had a factual question to ask. To what extent are swing beds still in place and play a role in this at all? They're rural. They're an odd sort of connection to many of these smaller hospitals. Access and issues have always been traditionally a part of what we look at in that context. But to what extent do they play in any of this?

DR. KAPLAN: I think they play in the access issue. They really don't play in the PPS yet. They will be in the PPS as of July 1 of next year, 2002. And they will be paid under the PPS.

My understanding is they will be advantaged by being paid on the PPS on that basis.

MS. BURKE: Just to close the loop. At some point we ought to think about the broad application of all these issues with respect to SNFs and what happens with those units as well, and what if anything we want to say about that. It's a very small universe, but for the people that have them there, sort of a critical component to this delivery system.

MR. HACKBARTH: We're down to our last few minutes now and I want to make sure that we give Sally what she needs to prepare for the next meeting. So if we can keep our comments brief, that will be helpful.

MR. MULLER: When the post-acute alternatives diminish, whether it's through these hospital-based SNFs or home care and so forth, one alternative clinically is obviously also to keep the patient in the inpatient setting, which discharge planners do because that's the safest alternative for them. So one thing, again it may take a while for us to see that, but certainly in my most recent U.K. experience I really see the effect of not having post-acute care. They stack up the hospitals.

So I think one thing we have to be sensitive to in looking at this, if these trends continue in any way, is there a kind of stacking up at the end of stay rather than going to the post-acute setting?

MR. HACKBARTH: Strictly on this point?

DR. NEWHOUSE: It's kind of where we're going. Because the consensus, as I heard it, was for more money for the hospital-based SNFs, but I think we need to have some discussion of what

magnitudes we're talking about, if that's where we're going.

MR. HACKBARTH: In fact that's the last piece I wanted to get to.

DR. REISCHAUER: One of the things both Sally and Sharon asked for guidance on was the update since the base seems to be okay, maybe except hospitals. We didn't talk at all when Sharon was here about the market basket minus. And the minus for home health was 1.1 percent. The situation for SNFs is 0.5 percent.

I'm wondering about the logic of having different minuses here. I presume this relates to unmeasured and unobservable productivity improvements. If I were sort of ranking industries or whatever sectors by potential for productivity improvement, it would depend very much on how technologically oriented, capital versus labor oriented, they were. And home health would be down near zero, as far as I was concerned. SNF would be a little bit above it.

Do you want us to talk about that kind of thing?

DR. ROSS: You're greatly overestimating where those two nicks came from.

DR. REISCHAUER: I know they have to save money, but I mean, we're trying to do this in a rational way going forward, right? Not to preserve irrationality, right?

MR. HACKBARTH: They are artifacts of the Congressional budget process, as opposed to estimates of productivity improvement, as you know better than any of us.

DR. REISCHAUER: For which I claim total innocence.

[Laughter.]

MR. HACKBARTH: So I interpreted the fact that we weren't dwelling on them was just a recognition of their origin and that we ought not be driven by them.

DR. REISCHAUER: But if they're crazy, then they create a problem with the base payment in the year or the year after. So maybe we can solve the problems before they arise, rather than after they arise.

DR. ROSS: I think in both of these settings, the elephant in the room is not the minus 1.1 or the minus 0.5. If you look at home care, it's the 15 percent, or whatever it will turn out to be, payment change scheduled for next year. And if you look at SNF care, if you look at the margins that we've presented, it wouldn't seem that minus 0.5 is going to be the story in that, in terms of payment adequacy.

DR. REISCHAUER: I'm just trying to make myself Carol's most favorite commissioner.

MS. RAPHAEL: A couple of points. Sally, as I recall from a study that was done last year, and I'm wondering if you can just update us. I have three points to make.

The first is I seem to recall that there had been a study that showed there was no significant change in case mix over the last decade in nursing homes. No? Am I...

DR. KAPLAN: I'm not familiar with that study. And are we talking about nursing homes or SNFs?

MS. RAPHAEL: SNFs. Was there any work done taking a look at the mix of patients in SNFs?

DR. KAPLAN: Not that I'm familiar with. Other than what we

did, which was the APR DRGs, which was strictly SNFs and it was using the APR DRGs. And we showed that case mix went down from 1995 to 1999 a little bit.

I mean, it wasn't radically different. And that the difference between the hospital-based SNFs and the freestanding SNFs case mix, and also we had swing beds in that as well. But the difference between the hospital-based and the freestanding was 11 points. That was 11 points in 1999.

MS. RAPHAEL: I just wanted to try to remind myself of that study.

I personally believe that if we're going to have any add-ons for hospitals and we believe there's some value in trying to do that in the absence of an accurate assessment system here, I think it has to be tied to case mix, it's my own view, some way of measuring the case mix difference and having it tied to that. I don't know how to accomplish that.

But I think we just don't know enough on an ongoing basis about what's happening to case mix here. I see some changes in the composition of the SNF population myself in the last year or two, but it's hard to demonstrate what those changes are. So I kind of feel that we have to think about how we're going to try to demonstrate, if we're going to do any added payment how that is, in fact, buttressed by some clinical rationale.

The other thing I was going to ask you is when we've looked at hospitals we've looked at Medicare margins and we've looked at total margins. You gave us information on Medicare margins. We've received a good deal of information on total margins, which show a different picture.

I was wondering if you could comment on whether or not you do look at total margins and any influence they have in these considerations?

DR. KAPLAN: Deborah ran the margins for 1999 and she was unable to get any sense out of the total margins for the nursing home, for the freestanding SNFs. I want to revisit that again, but I haven't been able to find time to do that yet.

Basically, I know what the industry is saying, which is that Medicaid is very low paid. And I'm sure that in some states it probably is. I'm not sure that that's true across all 50 states. I think New York is well known for being generous in their payments.

MR. SMITH: We may need more time here, Glenn, because it seems to me we need to return to Floyd's request to try to design a blunt instrument and I think Carol wanted to go in this same direction.

The clinicians make, and I think in the paper Sally made, a convincing case that part of the cost difference is rooted in clinical issues. The case mix index differences and the comments that Floyd and Alan and Jack made, that's appropriate for us to try to figure out how to respond to. I don't know what the blunt instrument is. You suggested at the end of your presentation that it might be an add-on. Carol says we need to figure out what's the right metric to measure the add-on with. I think we need some more time with that. But it seems to me that's where we ought to head.

The argument has been made for distributional change, but we haven't spent enough time on what's the way to get that done.

MR. HACKBARTH: Let me see if I can summarize where we are. Looking at the table here, what I hear is a consensus that there probably is a financial issue with the hospital-based facilities. Because of cost allocation issues the exact magnitude is uncertain, but there seems to be a sentiment that it's real.

Even if it were true at one point that we had too many hospital-based facilities pre-transfer policy, there are legitimate important clinical reasons for them to continue to exist and we can't just happily watch while they disappear.

If we provide some special assistance, it ought to be in the form of an add-on, as opposed to something baked into the base forever more. And we need to target it as best we can from a clinical standpoint to the patients institutions in need.

I hear consensus around those points. Am I hearing correctly?

MS. BURKE: Glenn, I guess one question that I would ask, the decision to do an add-on rather than to adjust the base, there appears to be a fairly fundamental issue here with hospital-based units that doesn't seem to be temporary unless the case mix dramatically shifts.

So my question is why the add-on and why not a base adjustment that then doesn't become an ongoing sort of set of targets of let's just do away with the add-on this year?

MR. HACKBARTH: My thinking on that, Sheila, was that at some point down the road, hopefully before 2006, we'll have a new system. And so ideally, that's the way to fix this problem. What we're doing is trying to fix it between now and then, and an add-on seemed to be appropriate.

DR. KAPLAN: Then what I hear you saying to me is you want us to come back next month with a blunt instrument that somehow is clinically targeted, okay? Is that right? I have something in mind but I'd like to discuss it over with peers.

MR. HACKBARTH: Thank you, Sally.

MR. DEBUSK: Last word. Realizing that there's a real need here, there's no doubt about it, but the hospital affiliated SNF or owned SNF represents 3 percent of the total pie. There's 97 percent out there with that stand-alone that's got some major issues and some major problems as we go forward. So at our next meeting, I think we really need to get into -- and I'm sure you will -- but there's some major issues there that we're certainly going to need to address.

MR. HACKBARTH: I think, at least from my perspective, the reason the conversation focused on the hospital-based is captured in the table, that the freestanding, based on the best information we have available, look like they are doing, on average, pretty well.

MR. DEBUSK: But there's something like $58 or $60 per day that's going to sunset in the future, and I think if that truly sunsets, I think it's going to create some havoc in the industry because this Medicaid, the states are in trouble now, we know they're in trouble with this thing. It just won't go under the rug. It's going to be there, and right now Medicare certainly

helps the existence of this piece.

MR. HACKBARTH: Just one question about the table. For the freestanding projection for 2002, that includes an estimate of the loss of the money that disappears in 2003. So this is 9 percent after that special add-on disappears?

DR. KAPLAN: Yes. Those two add-ons disappear, not the add-on that is due to the refinement of RUGs.

MR. HACKBARTH: We need to call a conclusion to this discussion for now and we'll look forward to January.